Section B
Forms

Re: counselor

Adam Hamm
Insurance Commissioner

NORTH DAKOTA
INSURANCE DEPARTMENT

VOLUNTEER INFORMATION FORM

Name _____ ☐ Male ☐ Female

Sponsoring organization _____

Mailing address _____ City _____ ZIP _____

Telephone _____ Date of birth _____

Email address _____

Background information

Education:

_____

_____

_____

Paid work experience:

_____

_____

_____

Volunteer work experience:

_____

_____

_____

Special interests or hobbies:

_____

_____

Adam Hamm
Insurance Commissioner

NORTH DAKOTA
INSURANCE DEPARTMENT

STATE HEALTH INSURANCE COUNSELING PROGRAM
VOLUNTEER AGREEMENT/NO CONFLICT OF INTEREST

I, _____, agree to serve as a volunteer for the State Health Insurance Counseling program working through _____ (sponsoring organization). I do not have an active insurance license. I have no interest in or affiliation with any insurance agency, company or product.

I understand my volunteer services may include acting as a teacher, counselor, presenter or general resource person for Medicare beneficiaries and caregivers with respect to insurance-related matters covered in the SHIC training sessions. I will provide services in a professional and objective manner.

In the course of my volunteer services, I will NOT recommend, suggest, propose or otherwise advise the purchase, sale, renewal, termination or non-renewal of any particular insurance product or insurance provider to any client or group of clients.

I will not disclose or use confidential information obtained as a result of my association with or access to any client for personal gain or advantage for my employer, or for any other parties, or for any purpose not directly required by the SHIC program.

I recognize my obligation to respect the confidentiality of the client and to exercise good faith, integrity and my best judgment in all dealings with clients as a SHIC counselor.

I understand I must participate in at least one State Health Insurance Counseling education program each year to continue as a counselor. I understand and agree to adhere to all policies and guidelines of the State Health Insurance Counseling program.

Date _____ Signature _____

Address _____

Phone number _____

NORTH DAKOTA
INSURANCE DEPARTMENT

Adam Hamm
Insurance Commissioner

NORTH DAKOTA STATE HEALTH INSURANCE COUNSELING PROGRAM
MEMORANDUM OF UNDERSTANDING

with

_____
(sponsoring organization)

A. The sponsoring organization will:
- Adopt, for the purposes of providing this service, the official title of the North Dakota State Health Insurance Counseling (SHIC) program.
- Protect confidentiality by securing records and assisting counselors in doing so.
- Assure counselors attend training and other meetings relevant to the program; assure counselors report monthly contacts for grant purposes.
- Provide suitable space for training and counseling.
- Provide telephone, copying service, office supplies and required postage.
- Serve as a clearinghouse for counselor supplies/materials.
- Publicize the counseling program.

B. The North Dakota State Health Insurance Counseling Program office will:
- Provide job descriptions for counselors.
- Insure that initial and continuing training are provided to counselors.
- Provide informational materials, counselor certificates and ID cards.
- Provide expertise with problem case management issues.

This agreement will continue in effect until amended or terminated by either party with a 30-day notice.

Sponsoring organization's authorized representative:

_____	_____	_____
Name	Signature	Date

State program representative:

_____	_____	_____
Name	Signature	Date

NORTH DAKOTA STATE HEALTH
INSURANCE COUNSELING PROGRAM

Re: client

CLIENT AGREEMENT

The State Health Insurance Counseling (SHIC) program is administered by the North Dakota Department of Insurance with federal grant funds from the Centers for Medicare and Medicaid Services. I understand the following provisions and agree to counseling provided by a North Dakota State Health Insurance Counselor.

I understand the trained volunteer counselors will provide assistance and information including:

- Review of Medicare Part D, Medicare supplement, long-term care and other health insurance plans
- Coverage and claims conflicts
- Sorting out bills, reimbursement and benefit statements
- Referral to other agencies when necessary

Whenever possible, the volunteer counselors will provide me with the skills and tools to manage future information and claims on my own.

I understand volunteer counselors will not advocate or make decisions about my health insurance or promote any products or policies for sale. I understand the advice offered by program volunteers is NOT legal or financial advice and that I may need to consult an attorney, accountant, government office, public service agency, family members or other information resource before making final decisions.

The SHIC program, its volunteer counselors and sponsors are not liable for decisions I make based on information or assistance provided and I agree to hold harmless the program, its sponsors, and volunteers. The Department may contact me at a later date to evaluate the service.

_____
Client initials

All services are free and confidential.

AUTHORIZATION TO DISCLOSE INFORMATION

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a Social Security number will not affect the disclosure of other information. The Department will not condition services on your agreement to authorize disclosure of your health information but the purpose of the authorization may not be able to be met if you do not sign this authorization. Your treatment or payment for your treatment by a health care provider cannot be conditioned on the signing of this authorization. The information being disclosed may be subject to redisclosure and may no longer be protected by federal privacy regulations.

Name of client: (last, first, middle initial)_____
Street address:_____
City: _____ State: _____
Social Security number: _____ Date of birth:_____

CLIENT RELEASE AND SIGNATURE

1. I hereby authorize:
   Name of person/agency: _____
   Street address: _____
   City: _____ State: _____ ZIP code:_____

2. To release information to:
   Name of Person/Agency to Receive Information: _____
   Street address: _____
   City: _____ State: _____ ZIP code: _____

3. The following information is requested: (be specific)

_____
_____
_____
_____

4. The information identified above will be used for: (list each purpose)
To assist the State Health Insurance Counseling (SHIC) program in providing health insurance counseling.

5. This authorization to disclose information remains in effect until: (specify date) _____

OR: (specify event terminating operation of the release) _____

continued ...

CLIENT CONSENT: This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. You have the right to revoke this authorization at any time by notifying the provider in writing. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written or electronic transmission.

Signature of client: _____

Date:_____

Signature of parent/guardian or custodian (if needed and relationship):
_____

Date:_____

Signature of witness* (if needed): _____

Date: _____

*If a client is unable to sign his name, an "X" or other mark or symbol is acceptable in place of a signature, as long as it is witnessed. Otherwise, a witness signature is not required for this authorization.

Re: client

NORIDIAN®
Administrative Services LLC

Medicare

4305 13th Avenue SW
Fargo, ND 58103-3373

Noridian Administrative Services
Medicare *Part B* Release of Information Request

This is an Authorization for Release of Information form. Your signature on this form authorizes Medicare to release information to the person, agency, company or organization that you name below to Act On Your Behalf. The form will be on file for future Telephone, Written Correspondence, or Appeal Requests. Please be aware, the form is not valid unless all fields are completed, signed and dated.

Retain a copy of this document for your records.

BENEFICIARY INFORMATION (Person with Medicare)

Name: _____ Medicare Number: _____
(From your Red, White and Blue Medicare Card)

Date of birth: _____ Telephone number: _____

Address: _____ City:_____ ST:_____ Zip:_____

Reason Why You are Filling Out This Request (Please check one):
□ At Request of the Beneficiary
□ Other (Specify Reason):

_____

_____

Type of Information to be released (Please check one):
□ Release ALL Information
□ Specific Information to be released: _____

_____

Time Frame: (Please check one):
□ On-going release
□ Limited (give date range) _____to_____

Person, agency, company or organization to which you are authorizing Medicare to disclose your personal medical information:

Name: _____

Address:_____ City _____ST_____ Zip_____

Telephone number: _____

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

I authorize the use of a copy (including electronic copy) for this form and the disclosure of my personal medical information described above. I understand refusal to authorize disclosure of my personal medical information will have no effect on my treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

Signature of Beneficiary or Authorized Representative **Date**

If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation. (For example, Power of Attorney or Appointment of Representative)

Please Note:

This Release of Authorization Request allows Medicare to disclose information from your records to the requested person, agency, company or organization that you authorized. Therefore, the information disclosed pursuant to the authorization may be re-disclosed by the recipient and may no longer be protected by law.

You also have a right to revoke this Release of Information Request by contacting our office in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to the address below.

Return to:
Noridian Administrative Services LLC
901 40th Street South, Ste. 1
Fargo, ND 58103

If you have any questions regarding this form please contact us at:

1-800-MEDICARE (1-800-633-4227)

State Health Insurance Assistance Program (SHIP) Public and Media Activity Form (_ _)

Instructions: This form is for <u>all</u> SHIP Public and Media Activities. Use one form per activity, which can include in-person presentations, booths/exhibits, media or internet activities. Definitions of each type of activity are provided in the accompanying instructions.

SECTION 1 - TYPE OF ACTIVITY (Check only one type of activity A-G)

☐ **A. Interactive presentation to public**
- In-Person
- Video teleconference or satellite broadcast

Estimated # of attendees: _____
Estimated # of people enrolled (If any): _____

☐ **B. Booth/exhibit at health/senior fair, etc.**
Estimated # of people potentially reached: _____
Estimated # of people enrolled (If any): _____

☐ **C. Radio show (not a PSA or ad)**
Estimated # of people potentially reached: _____
times this show re-aired (if known) _____

☐ **D. Web-site event**
- Web conference/forum
- Interactive chatroom

Estimated # of people potentially reached: _____

☐ **E. TV/cable show (not a PSA or ad)**
Estimated # of people potentially reached: _____
times this show re-aired (if known) _____

☐ **F. Enrollment Event**
Estimated # of people enrolled: _____

☐ **G. Other: _____**
(e.g. PSAs, targeted informational mailing, newspaper/newsletter articles)
Estimated # of people potentially reached: _____
times this PSA re-aired/re-printed/etc. (if known) _____

SECTION 2 - ACTIVITY INFORMATION (Please provide the following information if applicable.)

Date of activity: _____ / _____ / _____
month / day / year

Time of activity: Start_____ Stop_____

If multiple dates: _____ / _____ / _____ through
_____ / _____ / _____

Total length of activity across all dates: _____ hrs
(round to nearest hour)

Event or group name:
_____

Location of event:
Address: _____
City, State, Zip: _____
County: _____

Name(s) of Presenter(s):
_____

Contact Name:_____
Contact Phone:_____

Type of Presenter(s):
☐ SHIP Staff/coordinator/sponsor
☐ SHIP Counselor/volunteer
☐ Other: _____

SECTION 3 - TOPIC FOCUS (Check all that apply)

☐ Medicare (Parts A and B)
☐ Non-renewal situation
☐ Long-Term Care
☐ Medigap/Medicare Supplements
☐ Fraud & Abuse
☐ Medicare Prescription Drug Coverage (PDP/MA-PD)
☐ Other Prescription Drug Coverage/Assistance
☐ Medicare Health Plans
☐ QMB/SLMB/QI
☐ Other Medicaid
☐ General SHIP program information
☐ Other (specific health topics--ESRD, diabetes):
_____

SECTION 4 - TARGET AUDIENCE (Check all that apply)

☐ Medicare beneficiaries and/or pre-enrollees
☐ Family members/caregivers of Medicare benes.
☐ Low-income
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or other Pacific Islander
☐ White, Not of Hispanic origin
☐ Disabled
☐ Rural
☐ Other (please describe, such as professionals):
_____

State Health Insurance Assistance Program (SHIP) Client Contact Form (_ _)

Counselor Name:

Counseling Location Zip Code:

__ __ __ __ __

Type of Client/Assistance Requested by: (check all that apply)

- ❑ Beneficiary (self)
- ❑ Couple
- ❑ Caregiver (family member, conservator)
- ❑ Agency

How Did Client Learn About the SHIP: (check one)

- ❑ CMS (1-800-Medicare, www.Medicare.gov, Medicare & You, CMS mailing)
- ❑ Presentations/Fairs
- ❑ State-specific mailings/brochures/ posters
- ❑ Agency (senior org, disability org, Social Security)
- ❑ Friend/Relative
- ❑ Media (PSA, ad, newspaper, radio, etc.)
- ❑ Other: _____
- ❑ Not Collected

Date of Initial Contact:

__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:

- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:

_____ **hours** _____ **minutes**

Date if Multiple Contact:

__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:

- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:

_____ **hours** _____ **minutes**

SECTION 1 – BENEFICIARY INFORMATION

Beneficiary Name:

_____ _____
First Last

Beneficiary Zip Code:

__ __ __ __ __

Representative Name (if applicable):

_____ _____
First Last

Beneficiary Telephone #:

(__ __ __) __ __ __ - __ __ __ __

SECTION 2 – BENEFICIARY DEMOGRAPHICS

Is this his/her first contact with a SHIP since April 1? ☐ **Yes** ☐ **No**
(If Yes, Complete this section. If No, Skip to Section 3)

Age:

Date of Birth: __ __ / __ __ / __ __ __ __ **OR**
month / day / year

- ❑ Under 65 years
- ❑ 65 – 74
- ❑ 75 – 84
- ❑ 85 or older
- ❑ Not Collected

Monthly Income:

- ❑ Below 150% of FPL
- ❑ At or greater than 150% of FPL
- ❑ Not Collected

$_____

Race/Ethnicity:

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White, Not of Hispanic origin
- ❑ Other
- ❑ Not Collected

Gender:

- ❑ Female
- ❑ Male
- ❑ Not Collected

Disabled:

- ❑ Yes
- ❑ No
- ❑ Not Collected

SECTION 3 – TOPICS DISCUSSED (check all that apply)

Prescription Assistance:

Medicare Prescription Drug Coverage (PDP/MA-PD):

- ❑ Plan eligibility, benefit comparisons
- ❑ Low-income assistance - eligibility, benefit comparisons
- ❑ Enrollment / application assistance
- ❑ Claims / billing
- ❑ Appeals/quality of care/complaints

Other Sources of Prescription Drug Coverage/Assistance:

- ❑ Medicare-Approved Drug Discount Card
- ❑ State Pharmacy Assistance Program
- ❑ Union/Employer plan
- ❑ Manufacturer's Assistance Program
- ❑ Discount plans
- ❑ Other: _____

Medicare (Parts A and B):

- ❑ Enrollment, eligibility, benefits
- ❑ Claims/billing
- ❑ Appeals/quality of care/complaints

Medicare Health Plans (HMOs, PPOs, PFFS, Special Needs Plans):

- ❑ Enrollment, disenrollment, eligibility, comparisons
- ❑ Plan or benefit changes/non-renewals
- ❑ Claims/billing
- ❑ Appeals/quality of care/complaints

Medicaid (enrollment, eligibility, benefits):

- ❑ QMB/SLMB/QI
- ❑ Other Medicaid

Medigap/Supplement/SELECT:

- ❑ Enrollment, eligibility, comparisons
- ❑ Change coverage
- ❑ Claims/appeals

Other:

- ❑ Long-Term Care
- ❑ Fraud and Abuse
- ❑ Military Health Benefits
- ❑ Employer Health Plan or Federal Employee Health Benefits Program
- ❑ Customer Service issues/complaints
- ❑ Other: _____